

ARTICLES

Preface

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I. THE SYMPOSIUM

On November 18, 1994, the Seattle University School of Law and the Seattle University Law Review proudly sponsored *A Symposium on the Legal, Medical, Ethical, and Societal Issues Surrounding Physician-Assisted Death*. This Symposium was notable not only for its timely subject matter, but also because it was the first of our annual symposia to be held under the auspices of our new parent institution, Seattle University. From the earliest planning stages, the Seattle University administration and academic community exhibited remarkable support and enthusiasm for this endeavor. The Symposium and this issue thus mark the beginning of what promises to be a long and mutually beneficial collaboration between the law school and Seattle University.

In the context of our affiliation with a Jesuit institution, the question of whether we as a society should countenance physician-assisted death¹ for the terminally ill presented an ideal subject for in-depth discussion, raising as it does complex questions that implicate the overlapping spheres of law, medicine, philosophy, ethics, and religion. Furthermore, the law school setting for the Symposium seemed particularly appropriate given that the societal debate over physician-assisted death appears destined to be played out increasingly within a legal framework. A brief survey of this legal landscape will

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1. I intend the term "physician-assisted death" to encompass those situations in which a physician writes a prescription for a lethal dose of medication with knowledge that the individual intends to take his or her own life (often referred to as "physician-assisted suicide"), and those situations, such as lethal injection, in which the physician both provides the means and performs the final act that causes the individual's death (often referred to as "voluntary euthanasia").

both illustrate the extent to which the law has taken the leading edge on this question and provide a useful introduction to the Symposium Issue.

Over the past several years, advocates have tried a number of approaches to the legalization of physician-assisted death. Their early attempts centered on state legislatures, where they sought legislation that would allow the terminally ill to seek help from physicians to end their own lives. As these efforts failed to produce results, advocates next turned to state initiative and referendum processes in which the question could be taken directly to the voters. In 1991, the citizens of Washington were asked to vote on Initiative 119, which would have legalized physician "aid-in-dying" for the terminally ill.² After a hard-fought battle that largely centered on whether the proposed statute had sufficient safeguards to protect against abuse, the voters in Washington defeated the initiative by a margin of fifty-four percent opposed to forty-six percent in favor.³ Similarly, in 1992, voters in California rejected Proposition 161,⁴ which would also have legalized "aid-in-dying," albeit with additional safeguards.⁵

Faced with defeats in Washington and California, various proponents of physician-assisted death hit upon an alternative and potentially more powerful approach to achieve their goal of legalized physician-assisted death for the terminally ill. Rather than relying on the limited and expensive state-by-state initiative processes, they began to raise federal constitutional challenges to state statutes that prohibit and criminalize assisted suicide.⁶

In fact, the genesis for this Symposium is a case in which just such a challenge was made. In *Compassion in Dying v. Washington*,⁷ the plaintiff physicians and terminally ill individuals challenged the constitutionality of Washington's statute that makes assisting a suicide a criminal offense.⁸ On May 3, 1994, a federal district court judge in

2. See OFFICE OF THE SECRETARY OF STATE, STATE OF WASHINGTON, VOTERS PAMPHLET 27 (Ed. No. 1, 1991).

3. See *Results*, SEATTLE TIMES, Nov. 6, 1991, at D6.

4. See Virginia Ellis, *California Elections*, L.A. TIMES, Nov. 5, 1992, at A3.

5. See OFFICE OF THE SECRETARY OF STATE, STATE OF CALIFORNIA, CALIFORNIA BALLOT PAMPHLET 68 (1992).

6. See, e.g., *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994) (holding Washington's statute criminalizing assisted suicide to be unconstitutional), *rev'd*, 49 F.3d 586 (9th Cir. 1995); *Quill v. Koppel*, 870 F. Supp. 78 (S.D.N.Y. 1994) (rejecting a federal constitutional challenge to New York's assisted suicide statute); *Michigan v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994) (rejecting a federal constitutional challenge to Michigan's temporary ban on assisted suicide), *cert. denied sub nom.*, *Hobbs v. Kelley*, 131 L. Ed. 2d 723 (1995).

7. 850 F. Supp. 1454 (W.D. Wash. 1994).

8. See WASH. REV. CODE § 9A.36.060 (1994).

Seattle struck down the statute, holding that it unconstitutionally burdened the Fourteenth Amendment rights of terminally-ill, competent individuals who wish to commit physician-assisted suicide.⁹ Clearly this case, if upheld by the Ninth Circuit, had the potential to radically alter the legal landscape of physician-assisted death.¹⁰ Even more important, litigants on both sides are determined to bring this issue before the United States Supreme Court. If the Court should in the future hold that states cannot constitutionally prohibit physician-assisted death for the terminally ill, then every state will be required to allow physician-assisted death in one form or another.

While the *Compassion in Dying* case was thus the spark for our Symposium, an equally important event occurred just days before we convened. On November 8, 1994, the citizens of Oregon through their initiative process approved The Oregon Death With Dignity Act.¹¹ With this Act, Oregon became the first place in the world to legalize physician-assisted suicide.¹² The statute, which is presently enjoined pending a decision on its constitutionality,¹³ allows a terminally-ill, competent individual to make a written request to a physician for medication with which to end his or her life.¹⁴

This, then, was the fortuitous timing of our Symposium: a few days after our neighboring state of Oregon had legalized physician-assisted death and a few days before the appellate oral argument to the Ninth Circuit in the *Compassion in Dying* case.

As reflected in the Symposium title, our intent was to generate a far-reaching interdisciplinary discussion on the issue. To this end, our panels were made up of a mix of academicians, practicing attorneys

9. *Compassion in Dying*, 850 F. Supp. at 1467.

10. The Ninth Circuit Court of Appeals eventually reversed the district court's decision. See *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995); see also *infra* text accompanying notes 36-39.

11. Mark O'Keefe, *Assisted-Suicide Measure Survives Heavy Opposition*, OREGONIAN, Nov. 10, 1994, at A1.

12. See The Oregon Death With Dignity Act (1994), reprinted in Kane v. Kulongoski, 871 P.2d 993, 1001-06 (Or. 1994). Prior to the passage of Oregon's statute, the Netherlands had the least restrictive euthanasia policy in the world. Euthanasia and physician-assisted suicide are technically illegal in the Netherlands, but specific rules, approved by the Dutch Parliament in 1993, protect physicians from prosecution if certain conditions are met. See Marlise Simons, *Dutch Move to Enact Law Making Euthanasia Easier*, N.Y. TIMES, Feb. 9, 1993, at A1. In order to avoid prosecution in the Netherlands, a physician must be able to show that the patient had no hope of recovery, was experiencing unbearable suffering, was competent and voluntarily requesting to die explicitly and repeatedly, and that another physician saw the patient and supported the decision. *Id.*

13. See *Lee v. Oregon*, 869 F. Supp. 1491 (D. Or. 1994); see also *Oregon's Assisted-Suicide Law is Blocked Pending Court Ruling*, N.Y. TIMES, Dec. 28, 1994, at A9.

14. The Oregon Death With Dignity Act, *supra* note 12, § 2.01.

and physicians, philosophers, ethicists and clergy, and advocates drawn from the community.

The first panel explored in detail the case of *Compassion in Dying*.¹⁵ The attorneys for the plaintiffs and for the State of Washington began by outlining their positions on the constitutionality of Washington's statute criminalizing assisted suicide. Professor Kenneth R. Wing, an expert in constitutional law, followed with an insightful critique of their constitutional arguments and some thoughts about how the sitting justices on the United States Supreme Court might analyze this question. The next panel moved from the constitutional to the more directly political realm, with each of the panelists representing a community organization within Washington that has taken a strong position on physician-assisted death.¹⁶

Following a spirited keynote speech and an equally lively question and answer period,¹⁷ the first afternoon panel took up the issue of physician-assisted death from the perspective of health care providers who regularly care for dying individuals.¹⁸ Finally, the afternoon concluded with an examination by philosophers and ethicists of the moral and ethical implications of physician-assisted death.¹⁹ The Symposium Issue is largely comprised of articles by members of these panels, and thus reflects the thought-provoking interchange between speakers and audience that characterized this Symposium.

15. The following individuals participated on this panel: Kenneth R. Wing, Professor of Law at the Seattle University School of Law and the University of Washington School of Public Health; Kathryn L. Tucker, senior associate in the law firm of Perkins Coie; and William L. Williams, Chief of the Health Division of the Washington State Attorney General's Office.

16. The following individuals participated on the second panel: Susan Dunshee, President of the Board of Compassion in Dying; Sister Sharon Park, Associate Director and Lobbyist for the Washington State Catholic Conference; Todd Maybrow, partner in the law firm of Allen, Hansen & Maybrow; and Jerry Sheehan, Legislative Director of the American Civil Liberties Union of Washington.

17. The keynote speaker was Giles R. Scofield, Associate Professor of Law at the Pace University School of Law, and Assistant Clinical Professor of Social Medicine & Epidemiology at Albert Einstein College of Medicine of Yeshiva University, Montefiore Medical Center. Professor Scofield's speech is reprinted in this issue.

18. The following individuals participated on this panel: Thomas Preston, M.D., Professor of Medicine at the University of Washington School of Medicine and cardiologist at Pacific Medical Center; Suzanne Johnson, attorney in private practice in Seattle, Washington; Peter M. McGough, M.D., President of the Washington State Medical Association; Peter Shalit, M.D., primary care physician in Seattle, Washington; and Donald E. Spencer, President of the Washington State Hospice Organization.

19. The following individuals participated on this panel: Albert R. Jonsen, Professor & Chairman, Department of Medical History & Ethics at the University of Washington School of Medicine; Paul T. Menzel, Provost and Professor of Philosophy at Pacific Lutheran University; and Father Robert J. Spitzer, Associate Professor of Philosophy at Seattle University.

II. THE SYMPOSIUM ISSUE

Professor Albert Jonsen leads off the Symposium Issue, using the events surrounding Initiative 119 and its aftermath in Washington as well as the recent events in Oregon to illustrate the nature of the modern "euthanasia" discourse.²⁰ He characterizes the current debate as one over the appropriate boundaries of individual autonomy in decision-making, with proponents of physician-assisted death arguing for an expansive view of individual autonomy and opponents contending that we must limit autonomy in order to protect the weak and vulnerable in our society from coerced or involuntary death.²¹

Having begun with the modern debate, Professor Jonsen then provides a historical perspective in which he examines the evolution in both terminology (from "mercy killing" and "euthanasia" to "assisted suicide") and theoretical underpinnings for physician-assisted death. Thus, we are reminded that the earliest justification for physician-assisted death was the principle of beneficence—the physician's obligation to relieve pain and suffering.²² It is only in recent times, as an outgrowth of our willingness as a society to recognize individuals' rights to refuse life-sustaining medical treatment, that we have come to ground physician-assisted death in notions of liberty and autonomy. Professor Jonsen explains that we have moved away from the classical philosophical arguments, which tended to speak in terms of whether euthanasia was "right" or "wrong," toward a more pragmatic and consequentialist analysis that asks whether we can achieve a balance that both effectuates the autonomy of those individuals who desire assisted death and protects those individuals who do not.²³ Perhaps Oregon will become the laboratory in which we test whether such a balance can be successfully achieved. Professor Jonsen concludes his article with a plea for vigilance, lest we as a society become too complacent in our acceptance of physician-assisted death.

In the next article, Professor Giles Scofield sets out to challenge the ways in which we think and talk about physician-assisted suicide.²⁴ He begins with a critique of rights analysis, which, in Professor Scofield's view, has led to a destructive societal dynamic in which individuals stand in the marketplace of ideas and simply hurl compet-

20. Albert R. Jonsen, *Physician Assisted Suicide*, 18 SEATTLE U. L. REV. 459 (1995).

21. *Id.* at 462.

22. *Id.* at 468.

23. *Id.* at 467.

24. Giles R. Scofield, *Some Myths About Physician-Assisted Suicide*, 18 SEATTLE U. L. REV. 473 (1995).

ing inviolate rights at each other.²⁵ He contends that this privileging of diatribe over discourse threatens our very democratic existence. As one who has previously lamented the "war mentality" that has gridlocked the abortion debate,²⁶ I am sympathetic to his call for civility and mutual respect as we talk with each other about physician-assisted death.

Professor Scofield moves on to challenge the proposition that those who support the "right-to-die" must also as a matter of logic support the "right to physician-assisted suicide."²⁷ In doing so, he questions the validity of the syllogism that lies at the very core of the current rationale for physician-assisted death: that assisted death is the logical next step in the fight for individual autonomy and the right to self-determination.²⁸ Professor Scofield contends that one cannot derive the positive right to assisted suicide from the negative right to refuse medical treatment, and he finds it supremely ironic that the very same right-to-die movement that has fought to demedicalize death now finds itself in the position of arguing for the medicalization of death in the form of assisted suicide.²⁹

Professor Scofield deconstructs the debate over physician-assisted death even further by suggesting that its very existence is symptomatic of much larger ills within our society. He challenges the morality of a people who would spend so much time arguing over whether individuals have the right to assisted death and so little time demanding justice in the form of a health care system that is available to all and devoted to improving the lives of those who turn to it for care.³⁰ In the end, whether or not one agrees with Professor Scofield's position, we can surely respect his charge to each of us that we reexamine our own values as we participate in the discussion about physician-assisted death.

The next two articles return us to the more traditional rights analysis that, despite Professor Scofield's reservations, we seem to have committed ourselves to in the near future. In comparing Ms. Tucker's legal formulation of the rights involved in cases such as *Compassion in*

25. *Id.* at 478.

26. See Annette E. Clark, *Abortion and the Pied Piper of Compromise*, 68 N.Y.U. L. REV. 265, 296-300 (1993).

27. Scofield, *supra* note 24, at 477.

28. *Id.*

29. *Id.* at 478.

30. *Id.* at 488.

Dying³¹ with that of Professor Larson's,³² one cannot help but be struck by the fact that each of them uses the same Supreme Court cases, *Cruzan*³³ and *Planned Parenthood v. Casey*,³⁴ to justify opposite conclusions on the constitutionality of state statutes that criminalize assisted suicide.³⁵ They are, of course, engaging in the kind of analysis that those of us in law teaching try so hard to instill in our students—distinguishing and analogizing Supreme Court precedent in a way that results in a coherent and cohesive legal framework that supports their respective positions. Both Ms. Tucker and Professor Larson recognize that the decision will ultimately turn on the level of constitutional protection afforded the liberty interest involved. The *Cruzan* opinion with its rather narrow view of the liberty interest in refusing life-sustaining treatment is obviously more helpful to Professor Larson's position, while *Casey* and its recognition of a realm of personal liberty free from government interference provides stronger support for Ms. Tucker's.

Some months after the Symposium, the Ninth Circuit Court of Appeals weighed in on the question of whether the United States Constitution allows a state to criminalize physician-assisted suicide for competent, terminally-ill individuals. The appellate court, in a 2-1 decision reversing the district court in *Compassion in Dying* and upholding Washington's statute, rejected the view that the Constitution encompasses a fundamental right to physician-assisted suicide.³⁶ In doing so, the majority argued that the Supreme Court's broad statements in *Casey* concerning the realm of protected personal liberty interests must not be extracted from the abortion arena and applied in this case.³⁷ The court focused instead on the long history of criminal prohibition of assisted suicide in this country, the differences between the withdrawal of life-sustaining treatment and assisted suicide, and Washington's strong interest in protecting vulnerable individuals from

31. Kathryn L. Tucker, *Physician Aid in Dying: A Constitutional Right*, 18 SEATTLE U. L. REV. 495 (1995).

32. Edward J. Larson, *Seeking Compassion in Dying: The Washington State Law Against Assisted Suicide*, 18 SEATTLE U. L. REV. 509 (1995).

33. *Cruzan v. Director, Mo. Dep't. of Health*, 497 U.S. 261 (1990).

34. *Planned Parenthood v. Casey*, 112 S. Ct. 2791 (1992).

35. The two federal district courts that have decided this question have also reached opposite conclusions. While the court in *Compassion in Dying* held that terminally ill, competent individuals have a protected liberty interest in committing physician-assisted suicide, a federal district court in New York rejected the existence of such a protected liberty interest. See *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994), *appeal docketed*, No. 95-7028 (2d Cir. 1995).

36. *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995).

37. *Id.* at 590.

coerced or involuntary assisted death.³⁸ In contrast, Judge Wright, in dissent, asserted that Washington's statute violates the fundamental right of terminally-ill, mentally competent adults to choose physician-assisted suicide to end their lives.³⁹ Now that the Ninth Circuit has issued its decision, it remains to be seen whether the Supreme Court will take up this question in the near future.

Dr. Peter McGough moves our attention from the constitutional to the medical realm.⁴⁰ In exploring the reasons why the issue has come to the fore in the 1990s, he questions whether assisted death is a solution that we as a society ought to embrace. In staking out his position, Dr. McGough asserts that physician-assisted death may compromise the element of trust that is so necessary to the physician-patient relationship.⁴¹ He further argues that the distinction, recognized by both the medical profession and the law, between allowing a patient to die from natural causes and intentionally causing an individual's death is critical to the ethical practice of medicine and to the protection of patients.⁴² He concludes his article with an acknowledgment that the medical and other healing professions have an obligation to improve their care of the dying, and unless and until they do so, the demand for physician-assisted death will continue.

In the next article, Dr. Thomas Preston provides a direct response to the traditional arguments advanced by Dr. McGough against physician involvement in assisted death.⁴³ Dr. Preston deplores the hypocrisy of the medical profession, which publicly opposes medical involvement in physician-assisted death and yet privately manages and hastens its patients' deaths every day in ways that he argues are morally and philosophically indistinguishable from assisted death.⁴⁴ Dr. Preston asserts that we use language to shape attitudes, and that by setting up false dichotomies where we distinguish, for example, between physician actions that allow an individual to die naturally and those that "kill," we merely delude ourselves about the extent of physician involvement in the timing and modes of their patients' deaths.⁴⁵ He concludes that the medical profession and the larger

38. *Id.* at 590-94.

39. *Id.* at 594-97 (Wright, J., dissenting).

40. Peter M. McGough, *Medical Concerns About Physician Assisted Suicide*, 18 SEATTLE U. L. REV. 521 (1995).

41. *Id.* at 525.

42. *Id.*

43. Thomas Preston, *Physician Involvement in Life-Ending Practices*, 18 SEATTLE U. L. REV. 531 (1995).

44. *Id.* at 543-44.

45. *Id.* at 537.

society must recognize this involvement and begin to construct a new moral measure by which to judge physicians' actions in facilitating, easing, and ending their patients' lives.

In the final article in the Symposium Issue, Dr. Donald Spencer moves beyond the debate over whether physician-assisted death should be legalized and envisions a world in which it is legal.⁴⁶ He asserts that health care providers, who may be called upon in the very near future to provide such services, are ill-prepared to do so. He further contends that the general public has very little understanding of death and of the alternatives for care available to those with terminal illnesses, particularly in the realm of hospice and in-home care.⁴⁷ He is concerned that individuals' decisions as to assisted death will be driven by unfounded fears rather than reality. Dr. Spencer provides a pragmatic and practical perspective in which he emphasizes the need for education of health care providers and the public. He also advocates advance planning on the part of health care providers so that if the day comes, they will have written procedures and standards in place that will allow for the safe and responsible provision of physician-assisted death services.⁴⁸

III. CONCLUSION

The articles within this Symposium Issue illustrate the deep historical, medical, professional, legal, ethical, and personal dimensions of this topic. They are not intended to, and of course could not, provide definitive answers on the question whether we as a society should endorse physician-assisted death. Rather, our goal in pursuing this Symposium was to advance the discussion in an interdisciplinary setting so that we all might better understand what is at stake in the debate. And so I commend to you the Symposium Issue.

46. Donald E. Spencer, *Practical Implications for Health Care Providers in a Physician-Assisted Suicide Environment*, 18 SEATTLE U. L. REV. 545 (1995).

47. *Id.* at 546.

48. *Id.* at 551.